STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155133	A. BUILDING 00 B. WING	09/23/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KINDRED TRANSITIONAL CARE AND REHAB-COLUMBUS	2100 MIDWAY STREET COLUMBUS, IN47201

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F0000		F0000		

This visit was for the Investigation of Complaints #IN00096255, #IN00096478, and #IN00096891.

Complaint #IN00096255 - Substantiated - Federal/state deficiencies related to the allegation are cited at F323.

Unrelated deficiencies are cited.

Complaint #IN00096478 - Unsubstantiated due to lack of evidence.

Complaint #IN00096891 - Unsubstantiated due to lack of evidence.

Survey dates:
September 21, 22, and 23, 2011

Facility number: 000058
Provider number: 155133
AIM number: 100283340

Survey team:
Diana Sidell, RN

Census bed type:
SNF/NF: 166
Total: 166

Census payor type:

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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	Medicare: 23 Medicaid: 120 Other: 23 Total: 166 Sample: 6 These deficiencies reflect state findings cited in accordance with 410 IAC 16.2. Quality review completed 9/27/11 Cathy Emswiller RN			
F0323 SS=G	The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. Based on record review, observation, and interview, the facility failed to ensure a resident received adequate supervision and assistance to prevent accidents in that one resident's personal pad alarm failed to sound when the resident stood unassisted which resulted in a fall. This affected 1 of 3 residents reviewed for falls in 3 sampled. (Resident #A) Findings included:	F0323	A. Resident had her w/c alarm switched out on 9/10/11. The alarm is checked every shift. The batteries are changed out monthly or as needed. B. Residents who have wheelchair/bed alarms as an intervention will have their alarms checked every shift. The batteries will be changed out monthly or as needed. C. The SDC / designee will	10/25/2011

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	Resident #A's record was reviewed on 9/22/11 at 9:00 a.m. The record indicated Resident #A was admitted with diagnoses that included, but were not limited to, left hip fracture, congestive heart failure, osteoporosis, high blood pressure, Alzheimer's disease, and dementia. An admission Minimum Data Set Assessment (MDS) dated 8/11/11 indicated Resident #A was moderately impaired - decisions poor; cues/supervision required in cognitive skills for daily decision making, required extensive assistance of two or more persons for physical assistance for transfers and toileting, did not ambulate, and had a history of falls before admission with no falls since admission. A care plan dated 8/18/11 indicated a problem of "Potential for falls and injuries r/t (related to) decreased safety awareness d/t (due to) dx (diagnosis of) dementia, hip fx (fracture), use [of] meds. Goal: Will remain free from falls and injuries i.e. No falls and injuries. Approach: Call light in reach, bed in standard position, encourage to call for assist when getting up, amb[ulate] with assist, encourage to lock w/c (wheelchair) brakes before transferring, monitor for changes in mobility, sitting and standing balance,		in-service staff on proper functioning of wheelchair / bed alarms, when to use alarms, how to monitor alarms, documentation of monitoring alarms and alarm monitoring. The DNS / designee will review wheelchair / bed alarm use, continued use of alarm and determine if discontinuation of alarm is appropriate. The DNS / designee will audit resident alarm documentation related to proper functioning daily for 2 wks, then once a week for 4 weeks, then every other week for 4 weeks until compliance is achieved for three consecutive months. D. The ED will review audits results of alarms during performance improvement committee for three months or until compliance is achieved for three consecutive months. E. October 25, 2011	

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	mental function, monitor for effectiveness and s/e (side effects) of medication, (9/4/11) sensor alarm chair & bed, (9/9/11) WBAT (weight bearing as tolerated), (9/12/11) toilet [after] & [before] meals; upon rising; before bed, (9/16/11) stand/ pivot/ transfer [with] max]imum] assist of 1)." Resident progress notes dated 9/4/11 at 9:00 a.m. indicated: "Staff nurse observed resident attempting to stand from w/c (wheelchair) and ambulate near nurses station. Unable to reach resident before landing on bottom on (R) side. [No] visible injury. Requesting to use restroom repeatedly. C/O pain [with] ROM (range of motion) majority of time. Difficult to assess for [increased] pain d/t (due to) dx (diagnosis): dementia...new order obtained for (L) hip & pelvis x-ray d/t hx (history) (L) hip fx, c/o pain...transport (awaiting) via stretcher to [local hospital] radiology at this time." A "Post Fall Evaluation" dated 9/4/11 indicated a new intervention for "PPA (pressure alarm) to bed and w/c. Bedrest." An "Emergency Department to Long-Term Care Discharge Summary" dated 9/4/11 indicated an unhealed fracture of the (L) hip with surgical			

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	hardware intact, an appointment was set up with ortho on 9/8/11, and "no intervention is necessary." An x-ray dated 9/4/11 indicated: "IMPRESSION: 1. Acute left femoral neck fracture/see below. 2. Postop right hip. DISCUSSION: There is an old internally fixed left femoral neck fracture using three surgical fixation screws extending from below the level of the left greater trochanter into the femoral neck and head. There is sharp angulation with narrow projecting at the inferior margin of the left femoral neck consistent with acute refracture. There is an anatomically positioned right hip prosthesis. No other acute osseous abnormalities. There is diffuse osseous demineralization without bony destruction...." An x-ray dated 9/4/11 indicated: "Trauma/right hip pain. IMPRESSION: 1. Anatomically positioned right hip arthroplasty. 2. No acute fractures. Resident progress notes dated 9/10/11 at 3:50 p.m. indicated: "Resident was heard yelling for help, upon arrival of Rm (room) on East hall, resident found on floor by sink, in BR (bathroom) by CNA, assessed per (name of RN), and assisted back to w/c. Alarm was not sounding. 2x2 hematoma on (L) occiput (back of			

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	head above collar) [with] 1 cm (centimeter) superficial cut, scant amt of bleeding, ice pack immed[iately] applied to head. 2x2 hematoma (L) [anterior] hand, skin intact, event was unobserved. Neuro [checks] initiated at this time, denies pain at this time..." Resident progress notes dated 9/10/11 at 4:10 p.m. indicated: "W/c alarm switched out, verified proper working order." A "Post Fall Evaluation" dated 9/10/11 indicated the intervention in place at the time of the fall was an alarm, which was checked and did not sound. A new intervention was put in place to change the pressure alarm (sounds when the resident is lifted off of it) to a personal safety alarm (clips to the resident and sounds when the connection is pulled away from the alarm) to the wheelchair. On 9/21/11 at 2:30 p.m., Resident #A was observed sitting in a wheelchair in her room with a family member seated beside her. The family member said Resident #A has had several falls since she has been in the facility. The personal safety alarm was in place and clipped to the resident's shirt. During an interview on 9/23/11 at 9:25 a.m., the Assistant Director of Nursing			

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	Services (ADNS) indicated nurses go through and check their alarms to make sure they're functioning and document this on the MARs (Medication Administration Records). She further indicated they did not know why the alarm did not sound, the nurse had documented for that shift the alarm was working, and the pad alarms are usually good for one year; it had just been placed on 9/4/11. A policy and procedure for "Accidents and Supervision to Prevent Accidents" with an effective date of 4/28/11, was provided by the Director of Health Services (DHS) on 9/22/11 at 9:10 a.m. The policy indicated, but was not limited to: "Policy: The center provides an environment that is free from accident hazards over which the center has control and provides supervision and assistive devices to each patient to prevent avoidable accidents. This included systems and processes designed to...Implement interventions to reduce hazard(s) and risk(s); and Monitor for effectiveness and modify approaches when necessary ...Monitoring and Modification: 11. Center has monitoring processes in place to: a. Ensure that interventions are implemented correctly and consistently b. Evaluate the effectiveness of interventions c. Modify or replace interventions, as necessary...."			

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	This Federal tag relates to Complaint #IN00096255. 3.1-45(a)(2)			
F0514 SS=D	The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized. The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes. Based on observation, interview, and record review, the facility failed to ensure clinical records were complete and accurately documented in that 2 residents failed to have new physician's orders written on the recapitulation orders before the physician signed the recapitulation orders. This affected 2 of 4 residents reviewed for complete and accurate records in a sample of 4. (Residents #A and F) Findings include: 1. Resident #A's record was reviewed on	F0514	Residents A's MAR was reviewed to ensure that medications were administered per physician order. The monthly physician orders (recaps) were reviewed for accuracy. Resident F's MAR was reviewed to ensure that medications were administered per physician order. The monthly physician orders recaps were reviewed for accuracy. Resident physician orders and recaps were reviewed for accuracy. Resident MAR's and TAR's were reviewed to ensure that the MAR's and TAR's accurately reflected the physician orders.	10/25/2011

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	9/22/11 at 9:00 a.m. The record indicated Resident #A was admitted with diagnoses that included, but were not limited to, left hip fracture, congestive heart failure, osteoporosis, high blood pressure, Parkinson's disease, Alzheimer's disease, and dementia. Telephone orders dated 8/24/11 indicated a physician telephone order for Lexapro (antidepressant also used for anxiety) 10 milligrams by mouth every day for anxiety. Physician's recapitulation orders dated and signed by the physician on 9/1/11 failed to include the order for Lexapro 10 milligrams by mouth every day. Review of the Medication Administration Records (MARs) indicated the Lexapro had been administered daily at 8:00 a.m. from 8/25/11 through 9/23/11. 2. Resident #F's record was reviewed on 9/23/11 at 1:00 p.m. The record indicated Resident #F was admitted with diagnoses that included, but were not limited to, diabetes mellitus, osteoarthritis, anxiety, and gastroesophageal reflux disorder. A "Therapeutic Intervention Request" dated 6/28/11 indicated: "This resident is		The SDC / designee will in-service Licensed Nurses and Medical Records on Kindred policy and procedure for accurate recapitulation of physician orders. The DNS / designee will audit physician orders recapitulation orders, and MAR's and TAR's for accuracy daily for 4 weeks then monthly until compliance is achieved for at least 3 months. ED will review audit results during Performance Improvement Committee for three months or until compliance is achieved. E. October 25, 2011	

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	currently receiving Nasonex Nasal Spray for the management of rhinitis. The generically available Fluticasone nasal spray offers comparable safety and efficacy at a lower cost. Please consider discontinuing Nasonex Nasal Spray when supply is depleted and beginning Fluticasone nasal spray, 2 sprays each nostril once daily...." The response from the physician was an 'X' in the box for "I Agree". This Request was signed by the physician on 6/29/11. Physician's recapitulation orders dated 7/1/11 through 7/31/11 included an order for Nasonex 2 sprays each nostril daily, with a start date of 6/24/11. The recapitulation orders were signed by the physician on 7/1/11. Physician's recapitulation orders dated 8/1/11 through 8/31/11 continued to include the order for Nasonex 2 sprays each nostril daily and were signed by the physician on 8/1/11. Physician's recapitulation orders dated 9/1/11 through 9/30/11 included the order for Nasonex 2 sprays each nostril daily. Medication Administration Records for July 2011, August 2011, and September 1 through September 22, 2011 indicated the Nasonex had been initialed by a nurse as			

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	administered every day, or circled if held. Resident #F's medications were observed in the medication cart on 9/23/11 at 1:05 p.m. with LPN #1, there was no Nasonex in the medication cart, and there were 3 bottles of Flonase/fluticasone. LPN #1 was unable to indicate when the Flonase had been started. During an interview on 9/23/11 at 4:10 p.m., the Director of Health Services (DHS) indicated the unit managers reconcile the MARs and TARs with the physician's orders and the recapitulation orders. A policy and procedure for "Renewed or Recapitulated (Recap) Physician's Orders, Medication Records, and Treatment Records", with an effective date of 10/31/06, was provided by the DHS on 9/23/11 at 1:25 p.m. The policy included, but was not limited to: "Rationale: Every 30 days physician's orders are validated that physician orders are clear, complete, and signed order of a person lawfully authorized to prescribe. Physician's orders are reviewed and revised to include new orders, changed orders or to discontinue orders that have occurred throughout the month. Procedure: 1. Print physician orders in advance for nursing unit using RCS (computer			

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	system) or distribute recap orders from pharmacy. Orders are to be renewed: 2. Validate the physician's orders for accuracy. 3. Review new recapped orders with the old current orders. 4. Add orders that are missing from the recap orders. This may include, but is not limited to: a. Telephone orders that were obtained since the last full physician's orders. b. An order that may have been obtained during a consultant physician's visits and verified with the attending (i.e., Podiatrist, Dentist, Eye Doctor, etc....). 5. Discontinue physician orders by highlighting the order, drawing a line through the order, dating it as to when the order was discontinued and initialing. This may include, but is not limited to: a. Discontinuing a medication. b. Change in medication such as dosage and frequency. 6. Sign and date orders as reviewed. 7. Place in designated area on resident's char to await physician's visit...." A policy and procedure for "Medication Errors", with an effective date of 5/28/08, was provided by the DHS on 9/23/11 at 1:25 p.m. The policy included, but was not limited to: "Policy: Medications are managed and safely administrated to residents that minimize the opportunity for error. Definition: Medication Error: A medication error is any preventable			

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	event that may cause or lead to inappropriate medication use or patient harm while the medication is in the control of the health care professional, patient, or consumer...The observed preparation or administration of drugs or biologicals that is not in accordance with: a. Physician's Orders...5. A "recap" signed by the prescriber and subsequent orders constitute a legal authorization to administer the drug...." 3.1-50(a)(1) 3.1-50(a)(2)			